TESTIMONY ON

Medicaid's Role

by
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Mr. Chairman and members of the Committee, thank you for inviting me to appear before the Committee to testify about the role of the Medicaid program and the issues and challenges facing health and long-care coverage for the low income population. I am Diane Rowland, Executive Vice President of the Henry J. Kaiser Family Foundation and Executive Director of the Kaiser Commission on the Future of Medicaid.

The Kaiser Commission on the Future of Medicaid is a 14-member, bi-partisan national commission established by the Henry J. Kaiser Family Foundation in 1991 to serve as a Medicaid policy institute and forum for analyzing, debating, and evaluating future directions for health care for poor and vulnerable populations. I am pleased to be here today to share the work of the Commission.

MEDICAID TODAY

Since its enactment in 1965 as companion legislation to Medicare, Medicaid has operated as a federal and state partnership to meet the health needs of our nation's most vulnerable populations. Medicaid has evolved from a program providing financing to states for health coverage of their welfare population to a program that now finances health and long-term care services for over one in eight Americans and accounts for 15 percent of national health care spending. Its funding is the major source of financial assistance to the states, accounting for almost 42 percent of all federal grants-in-aid to the states.

Over the last 30 years, Medicaid has helped to close the gaps in care between the poor and non-poor, eased financial burdens for health care, and provided a safety net for the most needy Americans. It has been a major force in shaping health and long-term care services for low-income families and aged and disabled Americans. In 1995, Medicaid financed care for 35

million low-income Americans, covering one quarter of American children, and paying for 40 percent of the nation's births and half of all nursing home care.

Medicaid plays multiple roles for the diverse populations it serves. For 17 million children and 8 million adults in low-income families, Medicaid provides fundamental health insurance protection and keeps millions of poor parents and their children from adding to our growing uninsured population. For 4 million low-income elderly people and 5 million low-income people with disabilities, Medicaid provides both acute health care services and long-term care coverage for home and community-based care and nursing home care. For 6 million of these low-income elderly and disabled Medicaid beneficiaries who are also covered by Medicare, Medicaid pays Medicare premiums and supplements Medicare by covering cost-sharing and additional benefits.

Although children accounted for nearly half of Medicaid's 35 million beneficiaries in 1995, they consumed only 17 percent of program spending (Figure 1). Most Medicaid spending (59 percent) is attributable to elderly and disabled beneficiaries because of their complex health needs requiring in intensive use of medical care and costly long-term care services, especially in institutional settings. In 1995, Medicaid spent an average of $10,129 for an elderly beneficiary compared to $1,536 per child (Figure 2).

Medicaid provides coverage to millions of low-income families and elderly and disabled individuals, including segments of the population with costly medical and long-term care needs that are not generally covered by private insurance. In fulfilling this role, it has become a major budgetary commitment. Total federal and state spending for Medicaid services in 1995 was $151.3 billion, with the federal government's share accounting for approximately 57 percent of these expenditures.

MEDICAID ENROLLMENT AND SPENDING GROWTH

Medicaid is today a major issue on the policy agenda because of the size of the population it covers, the level of its spending, and its impact on federal and state budgets. Since the late 1980s, the number of people covered by Medicaid has increased from 22 million in 1988 to 35 million people in 1995 (Figure 3). During this same period, program costs have also grown, nearly tripling in combined federal and state spending from $52.6 billion in 1988 to $151.3 billion in 1995 (Figure 4). What accounts for this growth and what does it portend for the future?

Enrollment Growth

At a time when insurance coverage for the non-elderly population has been eroding, Medicaid has been the major vehicle for maintaining and improving coverage of the low-income population, especially poor children and pregnant women. Children accounted for the majority of the increase in the number of people covered by Medicaid in the 1988 to 1995 period. Today Medicaid provides health insurance coverage to over 17 million children in contrast to only 10.3 million children in 1988. As a result, Medicaid is on the front line as the insurer of one in four of our nation's children. Among America's children, Medicaid covers 33 percent of infants, 29 percent of preschool children (age 1-5), 22 percent of school-age children (6 to 12 years), and 17 percent of teenagers (13 to 18 years).

Escalation in Spending

Yet, it is not the extension of coverage to more children that explains the rapid growth in Medicaid spending over the 1988-1994 time period. Although children were the largest component of enrollment growth, they account for only a fraction of the spending growth because they have low per capita costs. Increased spending from coverage of more elderly and disabled beneficiaries with their higher per capita costs accounted for a greater share of the spending increases related to enrollment growth (Figure 4).

However, the major factor accounting for the spike in program spending in the early 1990s was not enrollment growth for these populations. The major growth factor was that some

states used provider taxes and donations and disproportionate share hospital (DSH) payments as a way to increase substantially the federal matching funds for the state. DSH payments were intended to allow states to increase payment levels for hospitals treating a high volume of low-income patients, but some states elected to broaden their use to secure additional federal financing for Medicaid. These creative uses of alternative financing approaches increased the base payments that had to be matched by the federal government and fueled the dramatic double digit growth in program spending from 1988-1992 (Figure 5). A high rate of medical inflation in the economy was also a contributor.

From 1988-1992, overall Medicaid spending grew at an average annual rate of 22.4 percent, but DSH payments had an annual growth rate of 149.9 percent (Figure 6). The greatest growth in DSH payments occurred from 1990-1992, when over half of the increase in Medicaid spending was attributable to increased DSH payments. In 1988, DSH payments accounted for $500 million, growing to $1.4 billion by 1990, $5.3 billion in 1991, and a dramatic increase to $17.5 billion in 1992. By 1995, DSH spending of $19 billion accounted for 12.6 percent of overall Medicaid spending and now is a greater share of total spending than spending for adults in low-income families.

The rapid escalation in DSH spending and the state practices promoting its use led to federal legislation to limit its growth and use. In many cases, states used DSH funds to finance uncompensated hospital care, but in other cases, DSH revenue served as a supplement to state general funds. Some states used the payments for programs unrelated to the delivery of health services. The curbs enacted in the Omnibus Budget Reconciliation Acts of 1991 and 1993 have essentially capped DSH funding and stemmed the rapid growth in Medicaid spending.

Slowdown in Spending

Since 1992, Medicaid spending and enrollment growth have slowed markedly, with the growth in spending declining from 22.4 percent per year from 1988-1992 to 9.5 percent per year

from 1992-1995. This slowdown is attributable to federal legislation implemented in 1991 and 1993 that restricted state use of tax and donation and DSH financing strategies combined with a relatively healthy economy and low inflation rates. Future increases are expected to be driven primarily by inflation and enrollment growth due to increases in the number of people in poverty and the required phase-in of coverage to children under 18 with incomes below the poverty level.

Assessing these trends and the evidence of a slowing of enrollment and spending growth in many states, analysis by the Urban Institute for the Kaiser Commission on the Future of Medicaid in December 1996 projected that spending growth for Medicaid would average 7.4 percent per year from 1996-2002. This was a notable slowdown in growth from the April 1996 Congressional Budget Office projections of an average annual increase of 9.7 percent during that period. In January, the CBO revised its estimates to predict average annual growth in Medicaid spending of 7.7 percent from 1996-2002. This lowering of projected Medicaid spending growth results from continued limitations on DSH payments and slower growth in enrollment levels and spending per beneficiary due to state cost containment efforts and an improved economy with lower medical price inflation.

On a per capita basis, the slowdown in spending is more dramatic because it measures Medicaid spending growth exclusive of the significant enrollment increases the program has experienced. In this regard, the recent experiences and future projections for Medicaid spending show moderate growth rates, expected to be comparable to those in the private sector. However, changes in the scope of benefits covered in private insurance and the shifting of some costs from employers to employees in the form of additional premium and cost-sharing responsibility make it difficult to compare private rate increases to Medicaid. From 1992 to 1995, Medicaid spending per beneficiary grew by 4.9 percent per year, and CBO projects future spending at an average of 6.0 percent per year over the 1996 to 2002 period.

These findings show that current federal and state efforts have constrained Medicaid spending. Much of the policy debate in the last Congress was fueled by the concern that Medicaid spending was out of control and needed to be reined in. It now appears this goal can be achieved without major program restructuring. If the CBO spending projections are borne out, Medicaid's contribution to the federal budget deficit will be substantially smaller than previously predicted. However, to the extent that slower spending reflects lower enrollment growth, the moderation in Medicaid spending could result in an increase in America's already large uninsured population.

CHALLENGES FACING THE MEDICAID PROGRAM

Medicaid's role in providing acute and long-term care services to our nation's most vulnerable people and its widening safety net responsibilities have brought about notable improvements in coverage of low-income families and assistance to poor elderly and disabled Medicare beneficiaries. But this progress has also resulted in spending growth that has strained both federal and state budgets. The tension in the program comes from the pressure to maintain and expand services to the poor, elderly, and disabled while constraining the cost of the program's safety net role. These are the major challenges facing the program's future.

Meeting the Demand of a Growing Uninsured Population

The continued growth in the uninsured population is a major challenge for the Medicaid program. Medicaid is the primary source of financing and coverage for the low-income population and has been a critical force in moderating the growth in American's uninsured population. Without Medicaid, millions of our nation's poorest children would be without health insurance. Medicaid now covers 55 percent of all people in poverty, reaching 83 percent of poor pregnant women and infants and 87 percent of poor pre-school age children (Figure 7).

The impact of Medicaid expansions in reducing the size of the uninsured population is particularly noteworthy in the Southern states that have traditionally had the most limited Medicaid coverage. From 1989 to 1993, the number of uninsured children nationwide increased by 9 percent, while the Southern states experienced a 3 percent decline. Reflecting Medicaid's required coverage of young children and the still being implemented phase-in of coverage for adolescents, the largest decrease was for uninsured children under age 6 -- the focus of initial Medicaid expansion efforts (Figure 8).

While Medicaid has been instrumental in providing health insurance coverage to low-income children, not all children eligible for Medicaid are being reached. It is estimated that 3 million of America's uninsured children are potentially eligible for Medicaid under current law, but not enrolled. Some may be unaware that they are eligible for coverage and others may be unable to navigate the often complex route to establishing eligibility. Finding and enrolling these children in Medicaid offers an opportunity to reduce the number of uninsured children.

As employer-based coverage for low-income working families continues to decline, there is also growing pressure on Medicaid to assist with their health insurance needs. Among the 40 million uninsured Americans, two-thirds have incomes below 200 percent of the federal poverty level. Medicaid is thus a primary building block in both federal and state efforts to expand health insurance coverage to low-income working families.

Eighteen states now have federal waivers of Medicaid law (known as Section 1115 Waivers) that allow them to experiment with changes in the scope and structure of their Medicaid programs to cover additional people and use managed care to restructure the delivery and financing of services (Figure 9). These waivers provide states with a way to use federal dollars to assist state efforts to expand coverage. Further advances on coverage of the uninsured population are likely to remain heavily focused on the Medicaid program as a way of providing financing for expanded coverage.

Using Medicaid as a vehicle to broaden insurance coverage of children uses an established program that can be targeted to the low-income population and has already become the dominant source of insurance coverage for one in four American children. Reaching out to seek additional enrollment for children who are eligible but not participating provides a logical and incremental strategy to improve health insurance coverage for children.

Sustaining the Safety Net for the Current Population

Medicaid continues to provide a wide range of services that assist the most vulnerable and frail in our society -- health insurance for impoverished children, assistance with Medicare's premiums and cost-sharing for poor Medicare beneficiaries, acute and long-term care services for persons with chronic mental illness and retardation, medical and long-term care services for those with AIDS, and home-based or institutional care for those with severe physical and mental disabilities that require long-term care.

These populations and the challenge of serving them fall uniquely to Medicaid because this type of coverage generally falls outside the purview of most private insurance policies as well as Medicare. On average, Medicaid beneficiaries are sicker than those with private insurance, require more care, and use more services. In many cases, Medicaid beneficiaries need highly specialized medical services or chronic care that is both expensive and difficult to manage.

States are now moving to enroll increasing numbers of their beneficiaries in managed care as a way of increasing access to primary care providers, coordinating their care, and controlling spending per beneficiary (Figure 10). These changes in the delivery system have the potential to improve care and accomplish savings. However, to be effective and preserve access to needed services, these changes will require time to implement, the development of an adequate infrastructure to deliver care, oversight of program implementation, and more experience with enrolling elderly and disabled beneficiaries with complex health problems.

Ensuring that plans have provider networks in place, educating both providers and beneficiaries about managed care, and responding to the unique needs of the Medicaid population will require increased effort as the share of beneficiaries enrolled in managed care continues to grow. States will need to be prepared to monitor implementation carefully, commit additional resources to program management, and assess the adequacy of the quality of care provided by providers and plans. These are new responsibilities that go beyond the functions performed by states under fee-for-service systems and will require additional resources at a time when most states are actively downsizing their state agencies.

Operating under tight budget constraints, Medicaid has often reimbursed providers at rates that are substantially below private-sector rates. If Medicaid payments to managed care plans, especially capitated plans that are fully at risk, are set below market rates to achieve savings, the participation of mainstream plans could be compromised. The promise of managed care may not be realized if this shift in care from fee-for-service to capitation is accompanied by payments that fail to keep pace with inflation or private sector rates, resulting in poorly financed plans and poor quality care for Medicaid beneficiaries.

In addition to the challenge of managed care implementation, Medicaid's future obligations with regard to coverage of its current beneficiary population are also highly dependent on potential changes in other programs - most notably, Medicare and welfare assistance. For 6 million low-income elderly and disabled Medicare beneficiaries, Medicaid serves as an essential adjunct to Medicare coverage by paying the Part B premium for all and assisting with cost-sharing and supplemental benefits for many. The pressure on the Medicaid program to assist the low-income elderly and disabled is likely to intensify in the future with the growth in the elderly population, especially the oldest old who are at greatest risk of needing nursing home care. Moreover, if future Medicare program changes result in increases in Medicare premiums, deductibles, or cost-sharing, new pressure will be placed on Medicaid to help fill these gaps.

Implementation of welfare reform also poses new challenges for Medicaid. Under the Aid to Families with Dependent Children (AFDC) welfare assistance program, Medicaid eligibility was automatic for welfare recipients. The new welfare reform legislation severs that link and will necessitate additional outreach to maintain Medicaid coverage of this population. As former welfare recipients move to work, there will be additional pressure to broaden Medicaid's coverage to the workers if the jobs they obtain are without insurance coverage.

Restraining Costs and Recognizing State Diversity

One of the most daunting challenges facing the Medicaid program is how to meet the growing need for health and long-term care coverage within the constraints of federal and state financing. Although Medicaid is jointly financed by the federal and state governments, many of the basic coverage and provider payment decisions that determine overall expenditures are made at the state level. Roughly 60 percent of all Medicaid spending is for populations covered and services offered at state option and not required by federal law or regulation.

The program's spending history has shown much volatility in recent years although spending patterns for Medicaid prior to the 1990s showed lower annual growth than private health care spending. The requirement for states to match federal dollars with state dollars has served as a constraint on overall spending. The notable exception is DSH and other state innovative financing practices that allowed states to accrue additional federal financing in the early 1990s. Eliminating such practices that allow states to spend federal dollars without commensurate matching funds from state revenues will help assure a moderation in future Medicaid spending.

National trends and aggregate statistics fail, however, to capture the extensive diversity in state programs both in terms of scope and spending. One of the factors contributing to the differences in states' Medicaid programs is the insurance environment at the state level. The western and southern states all experience relatively high levels of uninsured state residents,

with more than 20 percent of the population uninsured in California, Arizona, New Mexico, and Texas (Figure 11). Given these higher rates of uninsured, it is not surprising that Medicaid enrollment growth from 1988 through 1994 was highest in many of the states with the largest share of their population uninsured (Figure 12). Future trends are likely to reflect continued efforts to broaden the base of insurance coverage in these states.

But, states also have and commit different levels of resources to tackling coverage of the uninsured and low-income population. Federal DSH payments were originally intended as a way to allow states to pay more to providers that cared for a high volume of low-income (both Medicaid and uninsured) patients. These funds were drawn by states for this and other purposes, but the distribution across states on a per low-income person basis was very uneven (Figure 13). One of the lessons from the DSH experience for federal policymakers is the need to specifically target funds and assure that the states' ability to secure federal matching funds comports with legislative intent.

Finally, any attempt to provide national standards or caps on Medicaid spending needs to account for the variations in state programs and spending patterns. The rate of enrollment growth differs considerably from state to state, broad variation is seen in average state spending per beneficiary, and states have made different decisions in program structure resulting in large differences in the rate of growth in Medicaid spending. The changing composition of the covered population across states combined with differences in scope of benefits and provider payment levels has resulted in very different growth rates in overall spending as well as in spending per beneficiary in the states (Figure 14 and Table 1).

Caps on spending growth per beneficiary would have important distributional effects across states and would lock current differentials in levels of spending between states in place. It would penalize those states that have successfully controlled expenditures since they would face the same growth cap as states that have had more rapid historical growth. Moreover,

states that historically have had more limited benefit coverage would not be permitted to catch-up to spending levels of higher spending states.

Future Medicaid policy should be aimed at addressing the differences across states while maintaining and improving coverage of the low-income population. Restraining the rising cost of care for the vulnerable populations served by Medicaid without compromising the vital safety net role of the program is a daunting task.

CONCLUSION

There are no easy answers to reducing the cost of providing care to the over 36 million Americans who now depend on Medicaid for health and long-term care assistance. Nor are there any easy ways to extend Medicaid's protection to the millions of low-income uninsured individuals who fall just outside its reach. Those who depend on this program are among the poorest, oldest, frailest, and most disabled of our population. The challenge facing the program is how to sustain the safety net for the current population and meet the needs of a growing low-income uninsured population while restraining program spending and recognizing the substantial variation in state program design and spending.

Thank you for the opportunity to testify this afternoon. I welcome your questions.

Medicaid's Role

Summary of Testimony by Diane Rowland, Sc.D.

Role of Medicaid

- Today, Medicaid assists over 35 million low-income Americans. Medicaid is a health insurance program for low-income families, a medi-gap policy for poor elderly and disabled Medicare beneficiaries, and a long-term care program for the disabled and elderly.

- In its role as an insurer and safety net, Medicaid finances care for 1 in 8 Americans and 1 in 4 children, and pays for 40 percent of the nation's births and half of all nursing home care.

- Low-income children and their parents account for 72% of beneficiaries, but only 29% of spending. Whereas low-income aged and disabled beneficiaries account for 28% of enrollment but 59% of spending.

- Medicaid spending growth has slowed markedly from its high of 22.4% annual growth between 1988 and 1992 to 9.5% between 1992 and 1995. Future annual growth rates projected by CBO are 7.7% over the 1996-2002 period.

Challenges and Choices

  -- The major tension in Medicaid comes from the pressure to maintain and expand services to the poor, elderly, and disabled while constraining the cost of the program's safety net role and its impact on federal and state budgets.

  -- Medicaid remains the primary vehicle for providing health insurance to uninsured low-income children and families.

  -- Broadened use of managed care requires oversight, adequate financing and time to implement. In addition, it has limited potential for long-term savings.

  -- Reductions in already low provider payment rates, benefits, or program eligibility could compromise Medicaid's safety net role.

- In implementing the solutions to meet today's challenges, it is important not to undo the progress Medicaid has made in providing health and long-term care for millions of low-income and elderly and disabled people.

  -- Maintaining the safety net for children, the elderly, and the disabled should be a guiding principle in shaping Medicaid's future.

  -- States can be given greater flexibility to implement Medicaid managed care within the current program structure, but safeguards are necessary to assure that access to care, the range of benefits, and quality of care is sufficient to meet beneficiaries' health needs.

  -- Recent experience shows that savings can be achieved within the current program structure. State cost containment efforts as well as tightening federal control over state financing practices can be used to control future program spending.